STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G313	A. BUILDING 00 B. WING	01/25/2013

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ARC OF NORTHWEST INDIANA INC, THE	19038 MISSISSIPPI ST HEBRON, IN 46341

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W0000	This visit was for a post certification revisit (PCR) survey to the investigation of Complaint #IN00119881 completed on 12/14/12. Complaint #IN00119881-Not Corrected. Dates of Survey: 1/16, 1/17 and 1/25/13 Facility number: 000832 Provider number: 15G313 AIM number: 100249150 Surveyors: Christine Colon, Medical Surveyor III/QMRP-Team Leader Paula Chika, Medical Surveyor III/QMRP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/1/13 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on 1 of 1 incident of injury of an unknown source reviewed, the facility failed to report an injury of unknown source immediately to the administrator for client A. Findings include: 1. During the 1/16/13 observation period between 5:14 PM and 6:20 PM, at the group home, client A was in his bedroom laying in his bed. At 5:55 PM while looking at a previous wound area, client A had a quarter size to half dollar size dark red circular area on his lower right leg above the ankle. In the middle of the dark red circular area was a small open area. Five pen point scabs were around the dark red circular area. Client A's record was reviewed on 1/17/13 at 2:35 PM. Client A's 12/12 Repositioning Risk Plan indicated "...Staff should complete a visual inspection of [client A's] skin daily and document any changes on the daily logs and wound care sheet. If any redness,	W0153	Staff noticed the wound on this client while completing a body check. It was determined that this injury had occurred from client hitting his leg on the bed rail. Staff had been cleaning wound and applying antibiotic ointment. Once wound was found to have re-opened, the Service Coordinator and Community Services Nurse were notified and the Community Services Nurse went to the home and did a complete body check. The administrator was not notified as this was an old wound. To ensure future compliance, wound care procedures have been revised for all clients. New procedures will take effect in all homes by 2/24/13.2/19/13 Staff noticed the wound on this client while completing a body check. It was determined that this injury had occurred from client hitting his leg on the bed rail. Staff had been cleaning wound and applying antibiotic ointment. Once wound was found to have re-opened, the Service Coordinator and Community Services Nurse were notified and the Community Services Nurse went to the home and did a	02/24/2013

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	bleeding, or openings are noted staff are to complete an incident report...." Client A's Skin Assessment sheets from 1/13 to 1/16/13 indicated the facility staff did not document the above mentioned area on client A's right leg on the skin assessment sheets, and/or report the area to the nurse until 1/16/13 when it was brought to staff's attention. The facility's reportable incident reports and/or investigations were requested on 1/17/13 at 11:30 AM. Interview with the Service Coordinator (SC) on 1/17/13 at 11:30 AM indicated the facility was not able to provide any documentation of reportables and/or investigations as their computer system was down. Interview with staff #1 on 1/16/13 at 5:56 PM stated client A received the injury/area from "hitting bed rail with leg." Staff #1 indicated facility staff had been putting cream on the client's leg. Staff #1 retrieved an antibiotic cream and applied to the above area. Interview with LPN #1 on 1/17/13 at 3:20 PM stated client A received the area from "picking." The facility did not report the injury of unknown source immediately to the administrator.		complete body check. The administrator was not notified as the origin of this injury was known. To ensure future compliance, wound care procedures have been revised for all clients. New procedures will take effect in all homes by 2/24/13. Any incidents in which an injury of unknown origin occurs will be immediately reported to the administrator so that appropriate protective measure can be implemented and an investigation initiated. All investigation are monitored by the Quality Assurance director for thoroughness.	

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	9-3-2(a)			

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W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 sampled clients (A), the client's interdisciplinary team failed to address a client's identified behavioral need of skin picking. Findings include: During the 1/16/13 observation period between 5:14 PM and 6:20 PM, at the group home, client A was in his bedroom laying in his bed. At 5:55 PM while looking at a previous wound area, client A had a quarter size to half dollar size dark red circular area on his lower right leg above the ankle. In the middle of the dark red circular area was a small open area. Five pen point scabs were around the dark red circular area. Interview with staff #1 on 1/16/13 at 5:56 PM stated client A received the injury/area from "hitting bed rail with leg." Interview with LPN #2 on 1/17/13 at 3:20 PM indicated she was not aware of any areas on client A until she was called to	W0227	This client's behavior plan will be revised to include skin picking by 2/24/13. This is a rare occurrence, but as it detrimental to this client's skin integrity, it will be added to his plan.To ensure future compliance, any client that has a behavior that aggravates a medical condition will have a team meeting to discuss revision of the behavior plan. 2/19/13 This client's behavior plan will be revised to include skin picking by 2/24/13. This is a rare occurrence, but as it is detrimental to this client's skin integrity, it will be added to his plan. To ensure future compliance, staff will report any change in client's behaviors including those that aggravate medical conditions to the Service Coordinator through incident/accident reports or daily logs. The Service will collect data from these sources and observation. The Service Coordinator will then hold an interdisciplinary team meeting to initiate or revision the current behavior plan to address the emerging behavioral concern.	02/24/2013

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	the group home to assess the client on 1/17/13. LPN #2 stated client A received the area from "picking." LPN #2 indicated client A told her he picked the area. LPN #2 stated "He was picking today. Staff informed to redirect him." LPN #2 stated "he is a picker." Interview with Service Coordinator (SC) #1 on 1/17/13 at 2:10 PM stated "He does not do that (pick) unless he has a scab or scar." SC #1 indicated client A did not have a training objective/plan to address the client's picking. Client A's record was reviewed on 1/17/13 at 2:35 PM. Client A's 3/21/12 Individual Support Plan and/or 4/12 behavior plan did not indicate the client's identified behavior of picking was addressed. 9-3-4(a)			

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W0252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on interview and record review for 1 of 2 sampled clients (A), the facility failed to conduct/document daily skin checks/assessments on a client, and/or document repositioning of the client every 2 hours as outlined in the client's program plan. Findings include: Client A's record was reviewed on 1/17/13 at 2:35 PM. Client A's 12/12 Repositioning Risk Plan indicated "... [Client A] has been diagnosed with, osteoporosis, and incontinence, (sic) Due to these conditions [client A] is at risk for pressure ulcers related to immobility and incontinence. Baseline: [Client A] currently spends almost all the time he is awake in his wheelchair or bed. He needs to be transferred out of his chair and/or bed to relieve pressure on his back/buttocks as well as to encourage muscle movement." The risk plan indicated client A was to be repositioned every two hours to a bed, chair or couch. The risk plan indicated client A was to be checked and turned every 2 hours at night. Client A's Repositioning Risk Plan also	W0252	Wound care procedures have been revised for all clients. New procedures will take effect in all homes by 2/24/13.To ensure future compliance, the Community Services Nurse and Nurse Manager will monitor wound care sheets for completion.	02/24/2013

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	indicated "...Staff should complete a visual inspection of [client A's] skin daily and document any changes on the daily logs and wound care sheet...Staff are to notify the Nurse and Service Coordinator if any redness, openings, or bleeding is observed...." Client A's Repositioning Tracking sheets indicated no documentation client A was repositioned every 2 hours for the following: -1/3/13 12:00 AM and at 2:00 AM -1/6/13 6:00 PM, 8:00 PM and 10:00 PM -1/7/13 12:00 AM, 2:00 AM, 4:00 AM and 6:00 AM -1/9/13 12:00 AM, 2:00 AM, 4:00 AM and 6:00 AM -1/10/13 There was no documentation for the entire day from 12:00 AM to 10:00 PM. -1/14/16 6:00 PM, 8:00 PM and 10:00 PM Client A's Skin Assessment sheets from 1/13 to 1/16/13 indicated staff did not conduct and/or document daily skin checks/assessments on 1/7, 1/8, 1/9, 1/13,			

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	1/14, 1/15 and 1/16/13. Interview with staff #2 on 1/16/13 at 5:45 PM indicated facility staff were to document any open areas on the skin assessment sheets. Staff #2 indicated skin assessments/checks were done daily for client A and the completed sheets were sent to the nurse daily. Staff #2 indicated client A was to be repositioned every 2 hours. Interview with LPN #2 on 1/17/13 at 3:20 PM indicated facility staff were to complete daily skin checks on client A and document any areas they found. LPN #2 indicated daily skin assessment sheets were reviewed by the nurse daily. LPN #2 indicated she was covering for the nurse, for the group home, and she did not know where the 1/7, 1/8, 1/9, 1/13, 1/14, 1/15 and 1/16/13 skin assessment sheets were located if completed. When asked what the blanks meant on client A's Repositioning Tracking sheets, LPN #2 stated "They should be filled out." LPN #2 indicated client A was to be repositioned every 2 hours. 9-3-4(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 2 sampled clients (A), the facility's nursing services failed to ensure staff documented an injury on a body sheet, completed/documented daily skin checks as recommended, and/or failed to ensure facility staff followed nursing instructions in regard to a client's illness. Findings include: 1. During the 1/16/13 observation period between 5:14 PM and 6:20 PM, at the group home, client A was in his bedroom laying in his bed. At 5:55 PM while looking at a previous wound area, client A had a quarter size to half dollar size dark red circular area on his lower right leg above the ankle. In the middle of the dark red circular area was a small open area. Five pen point scabs were around the dark red circular area. Interview with staff #1 on 1/16/13 at 5:56 PM stated client A received the injury/area from "hitting bed rail with leg." Staff #1 indicated facility staff had been putting cream on the client's leg. Staff #1 retrieved an antibiotic cream and applied to the above area.	W0331	An incident report will be filled out for all new instances of skin breakdown for all clients. New wound documentation procedures will begin at all houses by 2/24/13.To ensure future compliance, the Community Services Nurse and Nurse Manager will monitor wound care sheets for completion.	02/24/2013

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	Client A's record was reviewed on 1/17/13 at 2:35 PM. Client A's 12/12 Repositioning Risk Plan indicated "...Staff should complete a visual inspection of [client A's] skin daily and document any changes on the daily logs and wound care sheet...Staff are to notify the Nurse and Service Coordinator if any redness, openings, or bleeding is observed...." Client A's Skin Assessment sheets from 1/13 to 1/16/13 indicated the facility staff did not document the above mentioned area on client A's right leg on the skin assessment sheets, and/or report the area to the nurse until 1/16/13 when it was brought to staff's attention. Further review of the client daily skin assessment sheets indicated staff did not conduct and/or document daily skin checks/assessments on 1/7, 1/8, 1/9, 1/13, 1/14, 1/15 and 1/16/13. Interview with staff #2 on 1/16/13 at 5:45 PM indicated client A did not have any open areas. Staff #2 indicated facility staff were to document any open areas on the skin assessment sheets. Staff #2 indicated skin assessments/checks were done daily for client A and the completed sheets were sent to the nurse daily.			

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	Interview with LPN #2 on 1/17/13 at 3:20 PM indicated she was not aware of any areas on client A until she was called to the group home to assess the client on 1/17/13. LPN #2 indicated facility staff were to complete daily skin checks on client A and document any areas they found. LPN #2 indicated daily skin assessment sheets were reviewed by the nurse daily. LPN #2 indicated she was covering for the nurse, for the group home, and she did not know where the 1/7, 1/8, 1/9, 1/13, 1/14, 1/15 and 1/16/13 skin assessment sheets were located if completed. 2. During the 1/16/13 observation between 5:14 PM and 6:20 PM, at the group home, client A ate a regular diet as the client ate solid food at the dinner meal. The meal consisted of beef rice and vegetables. Staff #1 placed the food on client A's plate. Staff #1 did not offer the client a liquid diet at the dinner meal. Client A's 1/2013 Medication Administration Record Book was reviewed on 1/16/13 at 5:19 PM. A 1/6/13 Medication Change Form indicated a new medication (Compazine 10 milligrams three times a day as needed) had been ordered to start for client A's nausea and vomiting. The 1/16/13 medication Change Form			

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	indicated "Continue clear liquids until [client A] has been free from vomiting and diarrhea for 24 hours. He may also return to workshop when free of vomiting & (and) diarrhea for 24 hours." Client A's record was reviewed on 1/17/13 at 2:35 PM. Client A's 1/16/13 Cumulative Medical Record indicated "Update from staff- [Client A] had diarrhea in the A.M. Immodium (diarrhea) given. One small bout after that. Ate lunch, will con't (continue) clear liquids-afebrile (no fever)." Interview with LPN #1 on 1/17/13 at 3:20 PM indicated client A should have received a clear liquid diet on 1/16/13. This federal tag relates to complaint #IN00119881. This deficiency was cited on 12/14/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			